VIOLET FAMILY DENTAL

Patient Name ______________________ Today's Date ______________________

Home Address ______________________ Date of Birth ______________________

______________________ Home Phone ______________________

E-mail Address ______________________ Cell Phone ______________________

Employer ______________________ Work Phone ______________________

Insurance Co. ______________________ Policy Holder SSN/ID ______________________

Policy Holder ______________________ Relationship to Policy Holder ______________________

Secondary Ins. ______________________ Emergency Contact and Ph # ______________________

Reason for Visit ______________________ Who Referred You? ______________________

PATIENT MEDICAL HISTORY

PHYSICIAN ______________________ OFFICE PHONE NUMBER ______________________ LAST EXAM DATE ______________________

Are you under medical treatment now? Y N

Have you ever been hospitalized for any operations or serious illnesses? Y N

Are you taking any medications (include non-prescription)? Y N

If yes, what medications are you taking?______________________

Have you ever taken Fen-Phen (Ionimin, Adipex, Fastin, Pondimin or Redux)? Y N

Are you allergic to any medications? Y N

If yes, what medication(s) are you allergic to? ______________________

WOMEN ONLY

Are you pregnant or do you think you could be pregnant? Y N If yes, when is your due date?______________________

Are you nursing? Y N Are you taking birth control? Y N

Do you have or have you had any of the following? Please circle if yes.

Anemia	Circulatory Problems	High/Low Blood Pressure	Stroke
Arthritis/Rheumatism	Cortisone Treatment	HIV/AIDS	Swelling of Feet or Ankles
Artificial Heart Valve	Diabetes	Kidney Disease	Thyroid Problems
Artificial Joints/Implants	Epilepsy/Seizures	Liver Disease	Tobacco Habit
Asthma	Fainting	Mitral Valve Prolapse	Tonsillitis
Autism/Sensory Issues	Glaucoma	Pacemaker	Tuberculosis
Back Problems	Hay Fever/Allergies	Radiation Treatment	Ulcer
Bisphosphonate Use	Headaches	Respiratory Disease	Venereal Disease
Blood Disease	Heart Murmur	Rheumatic Fever	Other ______________________
Cancer	Heart Problems	Scarlet Fever	
Chemical Dependency	Hemophilia	Shortness of Breath	
Chemotherapy	Hepatitis/Jaundice	Skin Rash	

PATIENT DENTAL HISTORY

How often do you brush? ______________________ How often do you floss? ______________________

Previous Dentist ______________________ Date of Last Visit ______________________

Please circle all that apply.

Bleeding Gums	Clenching or Grinding of Teeth	Sores/Growths Inside Your Mouth
Teeth Sensitive to Hot/Cold/Sweets	Teeth Sensitive to Biting	Loose/Broken Teeth or Fillings
Head/Neck/Jaw Pain	Head/Neck/Jaw Trauma	Frequent Headaches
Bad Breath	Periodontal Disease	Food Collection Between Teeth

I certify that I, and/or my dependant(s), have insurance coverage with ______________________ and assign directly to Donna C. Noll, D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my healthcare information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

SIGNATURE ______________________ DATE______________________